Uganda

Final Country Report

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The goal of the Family Planning Service Expansion and Technical Support (SEATS) Project is to expand access to and use of high-quality, sustainable family planning and reproductive health services.

John Snow, Inc. (JSI), an international public health management consulting firm, heads a group of organizations implementing the SEATS Project. These include the American College of Nurse-Midwives (ACNM), AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), World Education, and partner organizations in each country where SEATS is active.

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Acronyms

ACNM	American College of Nurse-Midwives
AIDS	Acquired Immune Deficiency Syndrome
ANSFS	Association Nationale des Sage Femmes du Senegal
ARO	Africa Regional Office (SEATS)
CA	Cooperating Agency
CAFS	Center for African Family Studies
CMS	Commercial Marketing Strategies
CPR	Contraceptive Prevalence Rate
CQI	Continuous Quality Improvement
CYP	Couple-Years of Protection
DHS	Demographic and Health Survey
DISH	Delivery of Improved Services for Health
DMO	District Medical Office
FINCA	The Foundation for International Community Assistance
FP	Family Planning
GOU	Government of Uganda
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
ICO	Independent Clinics Organization
IDR	Institute for Development Research
IEC	Information, Education and Communication
IMF	International Monetary Fund
INTRAH	International Training and Health
JHU/PCS	Johns Hopkins University/Population Communication Services
JSI	John Snow, Inc.
LAM	Lactational Amenorrhea Method
LC	Local Council
LTPM	Long-term and Permanent Methods
MAPS	Midwifery Association Partnerships for Sustainability
MIS	Management Information Systems
MOH	Ministry of Health
MW	Midwife
NGO	Non-Governmental Organization
NRM	National Resistance Movement
PR3	Performance Result #3 (Leveraging)
PSI	Population Services International
PVO	Private Voluntary Organization
PY	Project Year
QOC	Quality of Care
RA	Resident Advisor
RHC	Reproductive Health Care

SEATS	Family Planning Service Expansion and Technical Support Project
SDP	Service Delivery Point
STI/STD	Sexually Transmitted Infection/ Disease
SOMARC	Social Marketing for Change
TA	Technical Assistance
TFG	The Futures Group
TFR	Total Fertility Rate
TOT	Training of Trainers
UNDP	United Nations Development Programme
UNMC	Uganda Nurses and Midwives Council
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WHO	World Health Organization
WRA	Women of Reproductive Age
ZNA	Zambia Nurses Association

I. EXECUTIVE SUMMARY

Uganda, often referred to as "The Pearl of Africa," was once one of the leading countries in Africa in terms of economics, education, and health care. Between 1972 and 1986, however, Uganda had seven different ruling regimes and suffered greatly during 14 years of civil war. The infrastructure and economy of the country collapsed, many professional leaders and workers left Uganda or were killed, and the lives and morale of the populace were decimated. In 1986, the National Resistance Movement (NRM) gained control of the government and remains in place today. Uganda is once again emerging as a leader in the African and global communities, undertaking economic, political and healthcare reforms and programs.

The Uganda Private Midwives Association (UPMA), the professional organization for private midwives, was founded in 1948. During the civil war it became non-functional and was not fully re-organized until approximately 10 years ago. In 1991, UPMA requested assistance from the United States Agency for International Development (USAID)/Uganda and the USAID-funded Family Planning Service Expansion and Technical Assistance (SEATS) I Project implemented by John Snow, Inc. Between 1991-1994, SEATS I with its partner, the American College of Nurse-Midwives (ACNM), provided training in family planning/reproductive health care (FP/RHC) service delivery for 137 private midwives and developed a system of regional representatives within UPMA. The effectiveness of this subproject highlighted the important contribution private midwives could play in meeting family planning needs in Uganda and laid the groundwork for successive interventions under SEATS II.

In November 1995, SEATS II conducted a needs assessment that showed the main constraints facing UPMA were insufficient finances, inadequate financial and organizational management skills, unrealistic time demands placed on volunteer officers and a limited infrastructure. At the same time, the bilateral Delivery of Improved Services for Health (DISH) Project was mandated to provide comprehensive FP/RHC training for both public and private sector midwives, but no interventions were planned to address the sustainability of private providers or of UPMA through capacity building. Under the SEATS II Special Initiative, Midwifery Association Partnerships for Sustainability (MAPS), a two-year (1995-1997) subproject was designed and implemented to address these issues. During the lifetime of that subproject, the organizational structure of UPMA was expanded to include a Board of Directors (including a financial advisor) and a full-time administrator. In addition, 145 private midwives were trained in business management skills and community mobilization. Follow-up visits to these trained midwives showed impressive increases in the number of clients utilizing their services as a result of interaction with the community as well as improved management of clinic finances and resources.

A second MAPS subproject (1998-1999) continued capacity building with UPMA through interventions that included developing an Association-owned and operated model clinic and training center, installing computerized financial and membership data systems, training administrative staff and UPMA leaders in financial and organizational management, developing strategic and business plans, conducting membership drives, and assisting aspiring private midwives. Linkages were developed between UPMA and the Uganda Nurses and Midwives Council (UNMC) for the development of private practice standards, and with the Commercial

Marketing Strategies (CMS) Project for development of strategies to market and promote both UPMA and the new clinic.

SEATS II monitored and evaluated selected quality interventions and was able to demonstrate improved knowledge and skills, baseline level of compliance with standards, increased access to family planning services and a high percentage of surveyed clients who were satisfied with the care provided by private midwives.

After almost a decade of interventions in Uganda under SEATS I and SEATS II, the institutional capability of UPMA is greatly improved and it is well positioned to enter the next century as a leader of FP/RHC services and an advocate for private midwives. As UPMA becomes more self-sufficient, it will be able to develop and sustain the types of programs and activities to ensure the quality of and access to FP/RHC services provided by its members, with decreased dependency on external funding and technical assistance.

II. PROJECT BACKGROUND

A. Country Background

Uganda is a landlocked nation more than 2,000 kilometers from the Indian Ocean and divided by the equator. There is a total land area of 241,038 square kilometers, comprised of wetlands, rain forests, arid plains and savannas. High-density settlement, subsistence farming and intense use of firewood for fuel are greatly diminishing the forested areas. Lake Victoria is one of the country's greatest natural resources, but overfishing, uncontrolled growth of the water hyacinth and poisonous materials being released into the lake are greatly diminishing this source of local food and income. (Appendix 1. Map of Uganda)

The population of Uganda is currently estimated at 22 million and is made up of approximately 40 different ethnic groupings. Ninety percent of Uganda's population live in rural areas, yet Uganda is densely populated with an average of 85 people per square kilometer.

Uganda gained its independence from Great Britain in 1962. From 1962 to1986, when the National Resistance Movement came into power, the national leadership changed seven times, accompanied by a devastating toll in life, property and infrastructure. Although Uganda is currently considered politically stable, having held its first democratic election of a president in 1996, there continue to be internal rebel and tribal uprisings and recurrent conflicts along the international borders with the Democratic Republic of Congo and Sudan.

Uganda is divided into 45 administrative districts, which are further divided into counties, sub-counties, parishes and villages. There are approximately 40,000 villages, consisting of 30-150 households each. There is a decentralized system of Local Councils (LC) and committees at five levels, representing the administrative divisions. Anyone above the age of 18 years is a member of the village level LC and can vote for the members who form the grassroots governing body. The responsibilities of the elected officials include health and women's issues. The LCs identify local problems, find solutions and formulate development plans for the community. Governing officials at the higher levels are elected from within the lower LC levels. This bottom-up

approach to governing is in great contrast to the previous authoritarian forms of government and has created an effective infrastructure for implementing a variety of health and development programs.

Governing regimes, prior to 1986, attempted to control the country by over-expanding the public sector at the national level and by diminishing the private sector, resulting in near economic collapse, rampant inflation and an overwhelming public sector burden. Over the past decade, the economy has been gradually recovering. In 1987, Uganda agreed to the economic structural adjustment program of the International Monetary Fund (IMF) and the World Bank as a way to win support from the international donor community. Recently, the economic gains have been enhanced by the repatriation of the Asian community, privatization of public sector holdings, re-structuring of taxes, cost-sharing for selected public services (e.g. health, education), decrease in the number of military and other civil employees, and the development of tourism. In 1996, the United Nations declared Uganda to have the thirteenth fastest growing economy in the world but cautioned that continued high population growth rates could outstrip any real gains in the economy.

Despite considerable strides in re-building the nation's infrastructure since 1986, travel and communications in Uganda are difficult and severely limited. The state owns and controls the main broadcasting system and a widely circulated newspaper. Smaller, privately-owned mass media channels have limited ability to reach much of the country. Telephones are becoming more widespread in urban areas, but remain unreliable – and are almost non-existent in rural communities, as is electricity. English is the official language and is used for most printed media but is not understood by the majority of rural people. Repair of roads has been mainly in the capital city of Kampala, while much of the rural areas are difficult to access, especially during the rainy season. People in the rural areas rely mainly on walking and bicycles for transport.

Women in Uganda still have very limited control over their lives, despite steps taken to improve their status and condition. Women are taking a more prominent role in government, and the legal system is slowly changing to protect the rights of women and children. Makerere University has also taken positive actions to increase the number of women who are admitted for higher education; consequently, women are gradually assuming more important roles in the workforce. The majority of women, though, are still subject to traditional cultural practices which prevent owning land and property, receiving inheritances, possessing money, having choices about conception and contraception, and receiving adequate education. Practices such as widow inheritance, wife beating, bride price and polygamy are still common. Consequently, women in Uganda are at high risk in terms of poverty, illiteracy, malnutrition and anemia, maternal mortality and morbidity, and acquired immune deficiency syndrome (AIDS).

B. Demographic and Health Indicators

The World Health Organization's (WHO) 1999 World Health Report estimates the total fertility rate (TFR) in Uganda in 1998 to be 7.1. The infant mortality rate was recorded at 107 deaths per 1,000 live births (1998), and maternal mortality was estimated to be 1,200 deaths per 100,000 live births (1990). Currently, the total population of Uganda is estimated at 22 million with more than half under the age of 15 years. Women of reproductive age (WRA) comprise approximately

22.6 percent of the population. Life expectancy in Uganda is among the lowest in the world, estimated at 39 years for men and 40 years for women, due primarily to the AIDS epidemic.

The 1995 Demographic and Health Survey (DHS) showed that the use of modern contraception increased from a national average of 2.5 percent of married women in 1989 to 7.8 percent in 1995 (approximately 5 percent in the rural areas and 35 percent in the greater Kampala area). Sixty-eight percent of married women surveyed indicated a desire to have no further children or to space their next pregnancy by at least two years, with high unmet need for family planning among married women.

The relationship between high-risk pregnancies (birth interval less than two years, mother too young or too old or more than three previous births) and maternal and infant mortality has been demonstrated in many studies worldwide. In Uganda, two thirds of all births are characterized by one or more of these risk factors. Maternal mortality accounts for 17 percent of all deaths among women between the ages of 15-49. Although the majority of Ugandan women live within 10 kilometers of medical services, most utilize these services infrequently or late in pregnancy, and only about a third deliver with trained assistance. Reliable emergency transport is often non-existent, especially in rural areas.

The most significant factors contributing to child mortality are malaria, diarrhea, pneumonia, measles, AIDS and malnutrition. Seventy-seven percent of infants are breast-fed until two months of age, but only 36 percent are still breastfeeding at six months. Although the causes are still unknown, 38 percent of Ugandan children are growth stunted. It is estimated that the decrease in infant mortality by almost 20 percent in recent years will be replaced by an almost equal increase in infant mortality by the year 2010 due to AIDS.

There are approximately 1.9 million people infected with the human immunodeficiency virus (HIV) in Uganda. Although the DHS respondents indicate that knowledge about AIDS is almost universal, perception of risk of infection is low: 65 percent of women and 84 percent of men stated that they have little or no risk of infection. One study conducted at the AIDS Information Center, showed that 18 percent of married clients are discordant (one spouse is HIV positive and the other is HIV negative), indicating a significant risk even in stable relationships. Nearly one third of women who perceive their risk of AIDS as moderate to great have not changed their sexual behavior to reduce their risk of becoming infected.

Although AIDS continues to be a major problem, HIV prevalence seems to be declining among certain populations. HIV prevalence among pregnant women attending sentinel antenatal clinics peaked in 1992, with rates in Kampala and Mbarara around 30 percent. By 1995, the HIV rates had declined to around 12.5 percent. “Although the specific causes of this decline are difficult to document, it seems reasonable that they include several years of intense public education about AIDS, concomitant changes in behavior regarding multiple sexual partners, and an increase in condom availability and use” (USAID/ Uganda).

Sexually transmitted infections (STIs) are prevalent in Uganda, accounting for approximately 20 percent of adult outpatient visits. At sentinel clinics, 25 percent of pregnant women have an active syphilis infection. This is probably a low estimate due to the number of women who go untreated for asymptomatic infection.

C. The Ugandan Health Care System

The Ministry of Health (MOH) has as its goal to integrate family planning/reproductive health care services into all existing health facilities, yet currently many of the health units in the public sector and some in the private sector do not offer FP services by trained providers. While improvements in pre-service education are ongoing, there is still a large number of RHC practitioners (including midwives) who need in-service FP training. Consequently, most service providers are highly dependent on in-service training programs provided by both MOH and outside donor agencies. Some of the most significant recent programs and activities to address the MOH FP/RHC goal are:

- The development of National Policy Guidelines for Family Planning and Maternal Health Service Delivery (1993, MOH/INTRAH/USAID);
- Ugandan Demographic and Health Survey (1995, MFEP/ MACRO/USAID);
- DISH RHC training and service support in 12 districts (1994-99, Pathfinder/USAID);
- RHC training and service support in 16 non-DISH districts (1995-present, MOH/ UNFPA/WHO);
- Development of FP curriculum for pre-service programs (1995 MOH/JHPIEGO).

The Government of Uganda (GOU) is undertaking an extensive rehabilitation program to rebuild the nation's infrastructure through economic reforms, participating in regional collaborative programs and strengthening internal resources. The government has publicly recognized the negative impact of factors such as the AIDS epidemic, which is depleting the workforce, creating a large dependency group (orphans and the sick) and consuming valuable resources; the high fertility rate and population growth, which exceed economic growth and development; and inadequate education with resulting high illiteracy rates (average 54 percent). Uganda is taking positive steps in addressing each of these issues, but the magnitude of the problems makes progress slow.

Recently, Uganda has initiated a decentralized governmental structure, where principal responsibility for primary health care rests with district administrations, although the central MOH retains important policy making, quality control, technical assistance and monitoring and evaluation functions. "Most districts are ill equipped to cope with the problems noted above. The sector is characterized by the low salaries, skills and motivation of public sector staff, and by the insufficiencies in facilities, equipment, supplies, supervision, training and other support systems found in most health systems in sub-Saharan Africa. While many factors contribute to this, lack of resources underlie most of them, and getting more money into the health system and using it effectively is a major challenge facing the sector.

"Projected GOU/donor/household expenditures on health for 1996-1997 are about $202 million or about $10 per capita. Of this, about $36 million represent recurrent GOU expenses, another $36 million recurrent donor expenses, with the remaining $130 million (64 percent; a considerable resource if effectively utilized) being household expenditures. Recurrent GOU expenditures are thus about $3.60 per capita, a figure which would increase only slightly if capital expenditures were included. In addition to the small amount of public resources

available, the allocation of these funds is not cost effective. In 1994-95, only 11 percent of public health expenditures went for primary care while 78 percent was spent on hospitals and 11 percent on management.

"While a number of NGOs provide good quality services, they are often highly dependent on donor funding. Some of these organizations represent good opportunities for endowments for the long-term financing of at least some of their recurrent costs. Aside from perhaps as many as 800 midwives in private practice, there is very limited private sector provision of modern health care services outside of urban areas and few alternatives to public sector facilities.

"Although resource constraints will not be dramatically eased over the short-term, there are reasons for optimism. The policy environment is quite good. Despite the large amounts spent on hospitals, increased emphasis on primary care is an official priority, and the proportion of the MOH budget spent on hospitals is declining. In addition, cost recovery (fee for service) is now practiced in most public facilities. Although revenues collected are currently small and financial management procedures and controls are lacking, the MOH clearly views local revenue generation, alternative financing mechanisms such as insurance, and increased private sector provision of care as priorities.

"Re-orienting the system to primary care and prevention, including family planning, AIDS, and maternal and child health, is also an official priority. There are no policy obstacles to the provision of FP services. A substantial majority of women and men are favorably disposed to family planning and modern contraceptive prevalence has tripled over the past five years" (USAID/Uganda Country Strategic Plan, 1996).

The priorities of the GOU related to health are as follows:

- Restore the functional capacity of existing, war-damaged facilities and services;
- Improve staff morale and performance;
- Increase management capability at the district level;
- Increase the emphasis on primary care and disease prevention, especially in the areas of immunizations, maternal and child health, family planning, health education, AIDS, malaria, water and sanitation;
- Institute user fees and other forms of non-government financing;
- Promote private sector services.

D. Private Midwives in Uganda

The GOU recognizes the need to promote private sector services in order to have an impact on reducing the critical health problems facing the country, including HIV/AIDS, STIs, population growth, maternal and infant mortality and morbidity, malaria and diarrheal diseases. Private midwives have been providing preventative and curative services since approximately 1940. It is estimated that there are 800 private midwives in Uganda, who have the potential for

significantly extending and expanding the efforts of the Government of Uganda to provide accessible, quality FP/RHC services nationwide. Private midwives' services include antenatal and postnatal care, deliveries, family planning, immunizations and well baby care, syndromic management of STIs, HIV counseling, health education and minor curative services on a fee for service basis. Unfortunately, not all private midwives are capable of providing all of these services. Constraints to fulfilling private midwives' potential as service providers include lack of or inadequate training and continuing education, supplies, equipment, supervision and lack of access to capital for expanding/improving their services.

Ugandan private midwives are trusted members of their communities and provide FP/RHC services in urban, rural and semi-rural communities. They are often located in areas where public services are inadequate or non-existent, and are motivated to provide quality services in order to sustain their livelihood and local reputation. Several of these midwives have been elected by their communities to serve on the LC.

Midwives are licensed as practitioners by the Uganda Nurses and Midwives Council. They are sanctioned for private practice under the Nurses, Midwives, and Nurse Assistants Act and are registered with the District Medical Office (DMO) in the district where they work. Supervisory visits by the UNMC and/or the DMO are infrequent or non-existent due to lack of resources. Midwives do not have to meet any requirements or standards for continuing to practice, once they are established.

There are an increasing number of midwives expressing interest in private practice. Many of these midwives have retired from public service or are current practitioners seeking employment opportunities and options outside of the public sector. These midwives have the potential to significantly expand the number of private sector practitioners. Although the private sector in Uganda is critical to meeting the growing demand for health care needs, there is a limited number of private facilities and practitioners. Doctors often supplement their public service jobs by having private clinics, but they rarely practice outside of the larger cities; hence, the small number of private hospitals, clinics and projects in Uganda are limited to specific geographical areas. At present, only private midwives are practicing in both rural and urban communities nationwide, making them an important health care resource.

Midwives in Uganda at the Martyrs R.K. Clinic during the Zimbabwe/ UPMA study tour.

E. Uganda Private Midwives Association

The Uganda Private Midwives Association is a registered non-governmental organization (NGO), which was founded in 1948. UPMA is the official professional organization representing private midwives in Uganda and is a member of the Uganda Community-based Health Care Organization and the International Confederation of Midwives (ICM). Between 1966 and 1987, the instability in Uganda caused UPMA to become virtually non-functional, as most members lost family, property and equipment and were severely incapacitated as service providers. Since 1989, UPMA has re-established itself through the considerable efforts of its strong leadership and the commitment of the private midwives to be united in their service mission to the people of Uganda. UPMA is increasingly being invited to participate in programs, workshops and other activities that address RHC issues.

Of the estimated 800 private midwives in Uganda, 570 are members of UPMA and are located in 34 of Uganda's 45 districts. Approximately 25 percent are active (paying membership dues), although many more participate in Association activities.

UPMA conducts monthly, national meetings in Kampala with representatives from each of its 10 branches attending. A system of 30 regional representatives was created in 1993 to provide service support and supervision of members, communicate with headquarters and assist with commodity procurements. This system functioned until 1996, when it was discontinued due to lack of financial resources for transport. Currently, the system is being re-vitalized at some of the branches, through membership contributions. In 1996, UPMA re-structured its governing body, developing a Board of Directors and several standing committees. The Board of Directors includes non-UPMA members, who act as advisors in the areas of finance, program development and FP/RHC. UPMA maintains its headquarters in Kampala and in 1996 was able to build a small office building through donations from its membership and a grant from the Bancker-Williams Foundation. In June 1999, UPMA opened an Association-owned and operated clinic in order to strengthen and diversify its financial base and gradually reduce its dependence on donor funding, which at present is approximately 90 percent. All of the UPMA executive officers are elected by the membership and work as volunteers. The UPMA headquarters and clinic are staffed by salaried personnel.

Under the Social Marketing for Change (SOMARC) Project, UPMA headquarters was established as a sub-distributor for socially-marketed family planning commodities (oral contraceptives, condoms and Depo-Provera), which provides an income-generating source to the Association and reduces stockouts for members. UPMA also obtains free family planning commodities from the MOH central storehouse in Entebbe as a service to its members.

III. GOALS AND OBJECTIVES

A. USAID Uganda Strategy

Since 1990, USAID/Uganda has sponsored significant programs in maternal and child health, family planning (including contraceptive social marketing), AIDS/STI prevention and information, education and communication (IEC). Assistance has been provided in both the public and

private sectors. The largest USAID intervention has been through the five-year (1994-99) bilateral DISH Project implemented by Pathfinder International. USAID has also played a role in assisting the MOH to standardize financial management procedures in health facilities. The focus of DISH I was to provide in-service training in integrated FP/RHC to various cadres of service providers (including public and private sector midwives), improve pre-service RHC curricula, expand the availability of health services and information to Ugandans and enhance the financial sustainability of these initiatives. DISH II, which has been awarded to the Johns Hopkins School of Public Health's Center for Communication Programs (JHU/CCP), will commence late in 1999. The new project will continue the work initiated under DISH I but will be expanded to include additional areas such as child survival.

The current strategy of the Mission in addressing three of USAID's health objectives (reduced unwanted pregnancy, improved maternal health and reduced HIV/STI transmission) is to "intervene in these areas over the short to medium term to ensure the availability of good quality health services and encourage the adoption of behaviors, including but not limited to service utilization, which will reduce the risk of acquiring HIV, of unwanted pregnancy, and of maternal and child mortality" (USAID/Uganda Country Strategic Plan).

To accomplish the above objectives, USAID/Uganda is focusing its efforts on:

- Improving the skills of clinical service providers through in-service training;
- Establishing community outreach mechanisms to provide basic services and referrals to facilities with trained staff;
- Increasing the availability of contraceptives and STI drugs;
- Instituting supervisory mechanisms at community and facility levels, based on observed compliance with service standards;
- Facilitating implementation of the MOH health information system;
- Disseminating key information and advice related to reproductive health;
- Increasing the amount of non-GOU funding available for primary care;
- Encouraging private sector service provision;
- Improving pre-service training in RHC.

Ongoing programs will be continued and expanded in order to increase the number of public and private sector clinical staff (including nurses and midwives) capable of providing an integrated package of reproductive/maternal health services.

The SEATS interventions through UPMA have contributed directly to USAID/Uganda's strategic objective addressing health issues (SO4): Increased service utilization and changed behaviors related to reproductive/maternal/child health in selected districts. The Intermediate Results (IR) that SEATS addresses are:

- IR 4.1 Increased availability of reproductive/maternal health services;

- IR 4.1.1 Improved skills of clinical service providers;
- IR 4.2 Improved quality of reproductive/maternal health services;
- IR 4.2.1 Effective supervision of clinic and community staff;
- IR 4.3 Enhanced sustainability of reproductive/maternal/child health services;
- IR 4.3.3 Expanded member services provided by UPMA.

B. SEATS Country Strategy

SEATS offers a multi-disciplinary approach to family planning services which, while focusing on service delivery, has in-house strengths in such areas as management, quality of care, reproductive health, IEC, training, management information systems (MIS), policy development, finance, sustainability, and monitoring and evaluation. The SEATS II strategy in Uganda was to:

> **Assist USAID in achieving its strategic health objective – Increased service utilization and changed behaviors related to reproductive/maternal/child health in selected districts – through a private sector approach to enhance and expand FP/RHC service delivery provided by private midwives, integrating SEATS' resources and the MAPS Special Initiative.**

This strategy was implemented through two subprojects, studies focused on quality of family planning service delivery and inclusion of private midwives in regional activities. The implementation strategy was designed to increase access to the services provided by private sector midwives as well as to enhance the quality and sustainability of these services by increasing the institutional capacity of the Uganda Private Midwives Association. SEATS II activities were designed to complement and enhance existing programs and contributions of cooperating agencies (CAs) and donors. These include, but were not limited to:

1. USAID DISH Project – a five-year (1994-1999) bilateral project contracted to Pathfinder International and implemented through institutions in both public and private sectors. DISH focused on improving the quality and range of integrated FP/RHC services in 12 USAID intervention districts.

2. Johns Hopkins University/Population Communication Services (JHU/PCS) – the IEC component of the DISH Project, which focused on increasing access to the DISH improved FP/RHC service delivery points and effecting behavior change through extensive IEC campaigns.

3. International Training and Health (INTRAH) – the training component of the DISH Project, which provided in-service training in integrated FP/RHC services for both public and private sector nurses and midwives.

4. USAID SOMARC Project – a five-year (1993-1998) centrally-funded project implemented by The Futures Group (TFG). SOMARC developed the socially marketed contraceptive

commodities program in Uganda and linked a variety of private sector organizations to the social marketing program, as well as conducted an extensive IEC promotional campaign.

5. USAID CMS Project – a five-year (1998-2003) centrally-funded project implemented by Population Services International (PSI). This project is continuing the social marketing activities initiated under the SOMARC Project, as well as developing innovative financial programs to market, support and sustain FP/RHC programs and organizations in Uganda.

SEATS I and SEATS II have provided technical assistance to the Uganda Private Midwives Association since 1991 in partnership with the American College of Nurse Midwives, through three concurrent subprojects. Since 1995, implementation of two subprojects with UPMA has been accomplished under the SEATS II Special Initiative, Midwifery Association Partnerships for Sustainability. The focus of these subprojects has been capacity building and sustainability of UPMA, improving the quality of FP/RHC services offered by private midwives, and increasing access to FP/RHC services of private sector midwives in Uganda. Uganda is one of the few countries in which SEATS has had the opportunity to work with the same national partner for almost a decade, enabling each successive subproject to build upon the accomplishments and outcomes of prior interventions. The continuity of subprojects has served to increase the level of success experienced by each, and has enhanced the potential for sustainability of effective models and approaches to service expansion and improvement. It is anticipated that there will be a continuation of USAID/Uganda support for ongoing work with UPMA and private midwives, which attests to the success of SEATS' interventions with UPMA and the importance of private midwives as a valuable FP/RHC resource in Uganda.

During SEATS I, the three-year (1991-1994) subproject with UPMA had as its goal to expand maternal child health services by providing increased access to quality family planning care and information through private sector midwives.

Key accomplishments, which laid the foundation for subsequent subprojects with UPMA, included:

- Strengthened organizational capacity of UPMA through training of selected leaders in FP program management and quality of care, development of personnel policies and guidelines, development of tools to track membership and establishment of basic financial record keeping system;
- Established 130 new or improved service delivery sites;
- Integrated Lactational Amenorrhea Method (LAM) into FP method options;
- Trained 30 regional representatives to provide service support visits, collect service data, re-supply FP commodities, and provide a communications link between practitioners and UPMA headquarters;
- Developed linkage with the SOMARC Project resulting in private midwives being placed in market places to provide FP counseling and services, and UPMA being developed as a sub-distributor for both socially marketed and free (MOH) FP commodities;

- Assisted UPMA to leverage funds from a private foundation to purchase property for construction of a permanent headquarters site.

SEATS II began implementing activities in Uganda in 1995, primarily through the MAPS Special Initiative, with technical leadership from ACNM. MAPS focuses on promoting sustainability, through enhancing quality services provided by midwives and their professional associations; and creating regional linkages for midwives, in order to improve service delivery and strengthen professional associations through the sharing of resources and experience. The focus on associations maximizes the sustained technical and policy support necessary for maintaining high standards of quality and promoting service expansion beyond the life of donor-sponsored programs.

Key components of SEATS' Uganda program included:

- Increasing access to FP/RHC services by assisting aspiring private midwives and providing training in community mobilization;
- Improving the quality and integration of FP/RHC services provided by private midwives through the development of standards, continuous quality improvement (CQI) training, and facilitating the linkage between the DISH, SOMARC and CMS Projects for FP/RHC training and provision of socially-marketed commodities, respectively;
- Enhancing the sustainability of private sector midwives through training in business management skills;
- Enhancing the institutional capability and sustainability of UPMA through financial and organizational management training, computerization of membership and financial data, development of an Association-owned and operated clinic, development of a continuing education training center, and assistance with leveraging funds to expand association programs;
- Participating in SEATS regional activities;
- Integrating family planning into community programs by providing training and seed funds to two non-health sector NGOs.

The implementation and results of these activities are described in the following sections.

IV. PROJECT IMPLEMENTATION

A. MAPS I Subproject: 1995-1997

This subproject, initiated in 1995, was designed to strengthen the FP/RHC service provision capability and sustainability of private midwives who were members of UPMA and who were working in the 12 DISH Project intervention districts of Uganda. The DISH Project provided in-service FP/RHC training for both public and private sector midwives. At the same time, an extensive IEC campaign was launched to increase public awareness of the importance of child

spacing, HIV prevention and safe motherhood, as well as to seek the services of qualified FP/RHC providers. It was recognized, though, that under the DISH Project there were no planned interventions to either sustain private clinics operated by private midwives or to link the increased demand for services created by the IEC campaign and the FP/RHC services available from private midwives at the community level. The MAPS subproject was therefore designed to address these needs and three objectives were defined. The activities undertaken to achieve these objectives included community mobilization, small business management and association capacity building. The objectives, with their associated activities and outputs, are summarized below:

Objective 1: To expand the management and administrative capabilities of UPMA with a focus on sustainability of the organization and increasing member services and support.

- A needs assessment workshop for UPMA leaders was conducted and a strategic plan developed.

- A sustainability workshop was conducted which included training of UPMA leaders in marketing principles that could be applied to both UPMA and private practitioners, as well as image building to attract new members for UPMA, raise public awareness about private midwives and their professional association, and facilitate donor interest and support for needed in-service programs and education. The result was revision and printing of the UPMA brochure, revision of the strategic plan, and development of a sustainability plan.

- UPMA secured funding for the following programs and activities:

    1. Two workshops were held, jointly organized by UPMA and the Buganda Kingdom on Adolescent RHC and Safe Motherhood. Funding was provided by UNFPA and 150 midwives were trained;

    2. Two UPMA midwives participated in a WHO conference in Bahrain and presented a paper on antenatal care provided by private midwives in Uganda;

    3. Ten UPMA midwives attended the first East, Central and Southern Africa Obstetrical and Gynecological Scientific Conference on RHC held in Uganda and presented a paper on UPMA efforts to promote safe motherhood;

    4. Three UPMA midwives attended the third Reproductive Health Priorities Conference in South Africa and presented papers on UPMA efforts to promote safe motherhood and on the increased rate of abortions among adolescents in Uganda;

    5. The UPMA Chairperson attended the Home Birth Situations Conference in Sweden and presented a paper on homebirth in Africa.

- The MAPS Project Coordinator participated in a SEATS regional workshop in Harare, Zimbabwe, which reviewed key concepts and elements of quality and sustainability. Participants gained tools to identify critical issues impacting quality and sustainability and to monitor improvements. Participants developed plans to form quality teams and developed quality and sustainability plans for their organizations. This training provided UPMA with a resource person in these areas.

- Two UPMA leaders participated in a sustainability workshop held in the Ivory Coast. SEATS sponsored the participation of its NGO partners at this workshop conducted by the Institute for Development Research (IDR) and OIC International. More than 200 delegates from Africa attended.

- UPMA governance was restructured with revision of the Constitution and the development of a Board of Directors, including advisors in the areas of financial management, FP/RHC and program development, and the creation of five committees (finance, membership services, education, development, and fundraising). In addition, a full-time administrator was hired to oversee the day-to-day operations of UPMA.

- A membership survey tool was developed and a survey conducted through eight branch visits by the UPMA Executive Committee. There were 164 respondents with an average of 31 years in private practice (range of 4-42 years), representing approximately 27 percent of the total membership (active and inactive). Eighty-seven percent of UPMA members sampled expressed satisfaction with UPMA. Most frequent reasons for attending meetings were to receive clinical updates and share with other midwives; most frequent reasons for not attending meetings were work pressures at the midwives' clinics and lack of transport. Continuing education was the greatest need cited, and courses or updates on STIs and FP were most often requested.

- Through successful fundraising from the membership, UPMA constructed a permanent headquarters.

- Several books were purchased for the reference library at UPMA headquarters and UPMA was linked with resources that provide free periodicals and updates on FP/RHC.

- A training link was developed between DISH and UPMA. Although private midwives were to be included in DISH FP/RHC training, the selection of participants for training sessions was made by the District Medical Office, resulting in mostly public sector midwives being trained in the early phases of the DISH Project. In addition, private midwives were gradually not renewing membership in UPMA since they viewed DISH as potentially meeting more of their continuing education needs. MAPS assisted in resolving these problems by ensuring that a predetermined number of training places were allocated for private midwives with first priority being given to members of UPMA, ensuring that the letters of invitation for training were issued by DISH and UPMA jointly, and developing a communication channel between DISH and UPMA for feedback on trainee performance. In addition, IEC materials provided by DISH were also made available for resupply through UPMA.

Objective 2: To provide midwives with business skills to manage small, private FP/RHC service facilities.

- A needs assessment was conducted to determine the financial and business management areas that private midwives needed assistance with. It was discovered that the majority of midwives utilized a "story book" – a narrative form of recording clients seen, services rendered, anecdotal notes and monies received and spent. This type of recordkeeping system made it almost impossible to retrieve information needed to determine financial status or service trends, needs and utilization. Most midwives were co-mingling business and personal finances. Planning was found to be difficult, as most midwives lived from "day to day."

- A "Business Management Skills for Private Midwives: curriculum and Guide for Trainers" was developed. The purpose of the curriculum was to assist midwives who own and operate private RHC clinics to learn basic concepts and skills for managing their businesses more effectively and efficiently. Content areas included assessing needs and expectations of clients, obtaining client feedback, competition and marketing, record keeping and utilization of records for making business decisions, resource management, handling credit, and planning and budgeting. The correlation between continuing education, improving the quality and scope of RHC services, and business viability is emphasized throughout the Business Management Skills curriculum.

- Seven UPMA members were trained as trainers and initial training sessions were supervised.

- Eleven training sessions were conducted and 145 private midwives were trained in business management skills. Pre- and post-tests were administered and 100 percent of the trainees demonstrated improved knowledge and skills.

- A follow-up assessment tool was developed and site visits were conducted for 143 trainees within three months of training. It was found that 92 percent of the trained midwives were keeping improved financial records and 30 percent were utilizing all of the record keeping and management tools taught in the course. Those who were not utilizing their training stated health problems of their own or family members as the reason for delaying implementation. Initial follow-up assessments indicated that accuracy of record keeping, making a budget and developing an inventory list were areas that needed strengthening. As a result, additional time was provided during the last two trainings for supervised practice sessions, and follow-up showed a definite impact as each trainee was utilizing these tools correctly and with confidence.

Objective 3: To provide midwives with the capability to effectively interact within the community to promote greater awareness, access, and utilization of FP/RHC services.

- A needs assessment was conducted to determine what knowledge and skills the private midwives needed in order to interact effectively with the communities they served. It was found that the majority of midwives lacked the skills to assess community RHC needs and expectations, lacked confidence in reaching out to the community and frequently considered actively seeking clients as being "unprofessional." The latter is most likely a result of the regulations against advertising of medical services in Uganda.

- A "Community Mobilization for Private Midwives: curriculum and Guide for Trainers" was developed. The purpose of the curriculum was to provide private midwives with the knowledge, attitudes and skills which would enable them to interact with the community and to increase community awareness and utilization of the FP/RHC services which midwives provide, thus providing the link between demand for services and access to services. Training content included developing skills for assessing community FP/RHC needs and existing resources, identifying the role of the midwife in helping to meet these needs, learning ways to create awareness of services offered through active community participation and developing confidence in taking an active leadership role in community activities. Each trainee developed an action plan for increasing community awareness of her services.

- Seven UPMA members were trained as trainers and initial training sessions were supervised.

- Eleven training sessions were conducted and 145 private midwives were trained in business management skills. Pre- and post-tests were administered and demonstrated improved knowledge and skills.

- A follow-up assessment tool was developed and site visits were conducted for 143 trainees within three months of training. It was found that 95 percent of the trained midwives had implemented most or all of their community action plans. Client utilization of private midwives' services had increased significantly with an average monthly range of 10-26 percent increase.

The outcomes of these activities and outputs included increased contraceptive prevalence rates, increased couple-years of protection (CYP), increased client satisfaction and utilization of services (based on clinic attendance shown by quarterly statistics and review of clinic records during training follow-up site visits) and greater client acceptance of long-term (Depo-Provera) and permanent methods (based on quarterly statistics). These are further discussed in the next section (V. Accomplishments).

Although the subproject met all of its objectives, some constraints were encountered, which led to revision of some of the anticipated targets and activities, as well as difficulties in implementation. These included:

- As early as January 1996, reduced or delayed funding for FP programs caused USAID/Uganda to caution projects to "go slow" in view of funding uncertainties. Although field support was eventually provided during project year one (PY1) at the anticipated level for MAPS work in Uganda, planning and implementation were always conducted with a sense of possible closure or severe reductions at any time. Prolonged delays in receiving USAID field support monies (received July 1996) caused several of the activities called for in PY1 to be delayed until PY2. Field support monies were not available for the subproject in PY2 as previously "promised," causing a reduction in the training target of 220 midwives to 145, cancellation of one association development workshop and reduction in the number of TA trips to Uganda. SEATS essentially supported the subproject activities in PY2 with core funds.

- The funding constraints also affected the activities of the DISH Project with resulting slower implementation of FP/RHC training sessions and delay in developing the MIS mechanism. This MIS activity was intended to assist UPMA and MAPS in collecting service data and also to monitor the USAID SO4 Intermediate Result (IR4.3.3) indicator related to UPMA: number of clients utilizing private midwives clinics.

- The subproject called for training ten trainers in business management skills and community mobilization, but only eight midwives were identified in the DISH districts who met the requirements for becoming a trainer and one of these candidates died. As a result, seven trainers were trained, which proved to be an adequate number due to the reduction in the number of midwives to be trained as well as for ongoing UPMA training needs.

- Collection of service statistics from 145 midwives, representing 170 service delivery points (SDPs) proved to be extremely difficult. The vast majority of private midwives do not have telephones, and postal service was often unreliable in rural areas. Midwives were reminded to submit their service statistics at all meetings, and messages were passed by word of mouth and through radio announcements. Training sessions were conducted at branch meetings to instruct members on recording and submitting service data. As a result, an average of 56 percent of the midwives reported service data consistently, while others reported sporadically. It is reasonable to assume that the numbers of FP clients served and the total CYP generated during the subproject are considerably higher than what is reflected in the service statistics.

- Small reference libraries and re-supply of IEC materials at the branch level were not accomplished due to lack of safe storage facilities at the branches. It was the decision of the UPMA national and branch leaders to continue providing these services to members at UPMA headquarters only, until branch capability was expanded in the future.

- Subproject interventions were limited to private midwives working within the 12 DISH intervention districts, which was a requirement for receiving USAID/Uganda support. This created some conflict within UPMA, as members outside of the DISH districts viewed the national association as providing preferential services and opportunities to selected members. In response to these concerns, permission was sought and granted from USAID/Uganda to fill vacant training slots with non-DISH district midwives at the "last moment." Midwives signed up to be "on call," although most found it difficult to actually leave their clinics with less than 24 hours notice. The Hoima/Masindi/Kibaale branch conducted a self-sponsored training session in business management skills and community mobilization for its members.

Appendix 4 includes a complete list of references and documents that provide details on all aspects of the design, implementation and evaluation of this subproject.

B. MAPS II Subproject: 1998-1999

This 21-month subproject, initiated in April 1998, was designed to expand and sustain UPMA's role in significantly increasing access to high quality FP/RHC services provided by private sector midwives, resulting in increased service utilization. In order to assist UPMA to improve the

quality of private midwives' services on an ongoing basis and significantly increase the numbers of these service providers (i.e. improve access), USAID/Uganda mandated that the primary focus for interventions during this subproject was to lay the foundation for the sustainability of UPMA through increased financial and managerial capacity building. The MAPS subproject was designed to address these needs and six objectives were defined. The activities undertaken to achieve these objectives included training, assisting aspiring private midwives, developing practice standards, developing an Association-owned and operated clinic and training center, and Association capacity building. The objectives, with their associated activities and outputs, are summarized below:

Objective 1: To increase by 10 percent (over the life of the project) the number of midwives in private practice through enabling UPMA to assist midwives to establish, operate and sustain private practices.

- The Executive Committee and the MAPS Project Coordinator visited 9 of the 10 UPMA branches to meet with midwives who were interested in entering private practice. (One branch could not be visited due to insurgencies in the area.) Information about UPMA and private practice was provided, and a list of aspiring practitioners and their needs was compiled in order to facilitate follow-up and provide further assistance. A total of 83 aspiring private midwives were identified. Most frequently cited needs were access to start-up capital, basic equipment and information on how to start a practice and training in business management skills.

- A local consultant conducted a survey of a variety of credit and lending institutions and programs in Uganda, after being familiarized with the financial needs and situation of private midwives who either wish to open a clinic or expand an existing facility or services. The study was intended to provide midwives with information on accessing credit that is appropriate for meeting their needs and capabilities, as well as lay the groundwork for possible ways in which UPMA could seek funding opportunities on behalf of its members in the future. The findings of the survey showed that credit options in Uganda are very limited for private midwives, especially for those wishing to open a clinic.

- Delivery kits, the most basic equipment needed to start a private midwifery practice, were provided for 94 midwives. (Historically, twelve midwives were given delivery kits as gifts of appreciation when they were retired from public service. These midwives opened the first private practices in Uganda and went on to found UPMA more than 50 years ago.)

- Training in business management skills and community mobilization was provided for 77 aspiring private midwives. In addition to learning skills on how to manage a small business and obtain and handle credit, the midwives learned how to assess the health needs and expectations of the communities they wish to serve in order to determine what services to offer, how to choose a location and how to inform potential clients of their services.

- Although most of the trainees had not yet opened clinics at the time of training, follow-up visits were conducted to provide support and reinforce new skills and knowledge, as well as to learn how far these midwives had gone in taking steps toward opening a private practice. The findings showed that of the 83 aspiring midwives who were identified and assisted, 48 midwives had opened a practice in April 1998. Twenty-five had taken significant steps (e.g. obtained start-up capital, procured equipment, secured a location, applied for a permit) and anticipated opening a clinic by the close of 1999. Findings are discussed further in Section V. Accomplishments.

Objective 2: To establish UPMA's capability and role in setting, implementing and monitoring standards both for obtaining permits to open private practices and for ongoing certification to assure the provision of quality services by private midwives.

- A committee was developed with representatives from UPMA and the Uganda Nurses and Midwives Council, the national regulatory body, to jointly take responsibility for the development of standards and determine the feasibility of eventually utilizing standards in the granting of private practice permits and then monitoring ongoing practice. This was the first step in developing a linkage between UPMA and UNMC in regulating private midwifery practice.

- A collaborative workshop was conducted between UPMA and UNMC, with technical assistance provided by the American College of Nurse Midwives, resulting in the development of ten standards for private midwifery practice, as well as an action plan for adopting and disseminating the standards. (Appendix 2. Standards for Private Midwifery Practice)

- A follow-up workshop was held to further refine the standards and develop a context for their use and implementation. A representative from the MOH assisted UPMA and UNMC in finalizing the document. Approval has been sought from the MOH and is still pending.

- Research tools were developed and a baseline study was conducted to determine how midwives comply with the standards. Six standards were selected for this initial study (Standards 1, 3, 4, 6, 7 and 8). A convenience sample of 43 midwives was taken from four districts (Kampala, Mukono, Mpigi, and Masaka). The findings showed that the majority of the midwives sampled achieved an acceptable rating on five out of the six standards. Findings are discussed further in Section V. Accomplishments.

Objective 3: To establish UPMA as a center of excellence for in-service training in midwifery and reproductive, maternal and infant health services.

- Four continuing education modules were adapted from the DISH FP/RHC and the SEATS continuous quality improvement (CQI) training curricula: Continuous Quality Improvement, Family Planning Counseling, Family Planning Service Provision, and Management of Sexually Transmitted Infections. The modules range from three to five days in length and are designed to meet the continuing education needs most frequently requested by the UPMA membership based on the membership survey, be affordable to the midwives while at the same time generating income for UPMA, and not remove the midwife from her clinic for extended periods (a problem noted by private sector midwives taking the four to six-week DISH course). Each module is comprised of several short sessions that can stand alone and can be utilized at branch meetings to further assist midwives with limited time and resources to obtain essential updates.

- Pre- and post-tests were developed to assess effectiveness of the training sessions. Currently, UPMA does not have the capability to conduct follow-up visits on trainees, but this should be considered in the future.

- Four UPMA members were trained as DISH FP/RHC trainers, as well as trainers for the four continuing education modules.

- A training room was developed at the UPMA clinic site and basic training equipment was procured (e.g. reference materials, models and chalkboard).

- UPMA trainers have conducted business management skills and community mobilization sessions for midwives (including 77 aspiring practitioners) at four UPMA branches (Mbaale, Lira, Mbarara and Mukono).

Objective 4: To enhance the financial self-sufficiency of UPMA by increasing active membership; acquiring and successfully operating a private UPMA clinic and training site; and acquiring, through the submission of an acceptable proposal, an endowment from USAID/Uganda.

- Visits were conducted by the UPMA Executive Committee to nine UPMA branches in order to motivate inactive members and to identify and attract practitioners who were not previously members of UPMA. In response to UPMA's efforts, a group of approximately 30 midwives in Lira, who were not members of UPMA, asked the UPMA leaders to meet with them. Over the life of the project, UPMA has opened two branches (Lira/Apac and Eastern) and made special efforts to provide assistance to aspiring midwives in these areas. As a result of UPMA's concerted efforts to attract new members and reactivate dormant members, the membership has increased by 14 percent since April 1998. Approximately 25 percent of the membership have paid their annual subscription fees either fully or in partial installments.

Table 1. UPMA Membership

UNIT	Q2/98	Q3/98	Q4/98	Q1/99	Q2/99	Q3/99
Total membership at start of quarter	507	505	511	515	533	543
New members	1	7	4	20	11	27
Losses by termination of membership	-	-	-	-	-	-
Losses by death	3	1	-	2	1	-
Total membership at end of quarter	505	511	515	533	543	570

- A proposal was developed and submitted to USAID/Uganda and the Ministry of Finance and Economic Planning, securing funds from the Local Currency Special Account Program (PL480) to purchase and renovate a building for a UPMA clinic.

- Following a feasibility study, a building was purchased, renovated and equipped to accommodate a for-profit nursing home (polyclinic) that is owned and operated by UPMA. The purpose of the facility is to be a model of FP/RHC services provided by private sector midwives, provide a practicum training site, diversify the financial base of UPMA and provide needed FP/RHC services in the Kansanga community. Kansanga is located 6 kilometers from the heart of Kampala and has a population of 7,887 (1998), of which 27.3 percent are women of reproductive age.

- The clinic has the following service provision capabilities: antenatal, delivery, postnatal, family planning, immunizations, STI/HIV counseling, health education, ultrasound, laboratory (including HIV testing), pharmacy, minor curative, in-patient (men, women and children) and minor surgery including voluntary surgical contraception (VSC). On May 19, 1999, a ribbon cutting ceremony was held and on June 30, 1999, the Kansanga Family Nursing Home was officially opened to the community. As of the end of October 1999, health services have been provided for 721 clients.

- Clinic staff were recruited, job descriptions were developed, and the six staff midwives were provided with DISH FP/RHC training.

- Clinic cash-flow projections and an operating budget were developed and service fees were determined.

- In collaboration with the Commercial Marketing Strategies Project, MAPS assisted UPMA in developing marketing strategies to promote the UPMA clinic which included radio messages, newspaper articles, meetings with local leaders and health officials, a health fair, signboards and a pamphlet.

- A team building and quality of care workshop was conducted for all UPMA clinic staff to orient every staff member to the importance of offering quality services, to develop a mission statement for the clinic and develop strategies for achieving clinic goals.

- A supervisory committee was formed, made up of experienced, volunteer UPMA midwives who provide on-the-job training and supervision of the staff at the UPMA clinic and monitor the clinic's capability for meeting clients' needs. The committee makes recommendations to the clinic administration and UPMA Executive Committee.

Midwives open local clinic
By Sylvia Juuko

Uganda Private Midwives Association (UPMA) have opened a new family Nursing Home at Kasozi Lane, in Kansanga.

The facility which was opened May 19 is jointly funded by United States Agency for International Development (USAID) and the Ministry of Finance and Economic Planning.

A statement issued by United States Information Service (USIS) said that USAID has provided more than $2m to UPMA since 1991.

The funds have strengthened UPMA's ability to provide its membership with continuing education and service support to meet the growing demand for quality health services.

Family Nursing Home will be operated by the association and will provide antenatal, delivery, postnatal, family planning and general health care services to Kampala area, especially the Kansanga community.

The facility will also offer HIV counselling and testing, and diagnosis and treatment of sexually transmitted diseases.

UPMA was founded in 1948 as a professional organisation for private midwives representing over 500 private practitioners across the country.

Source: The Monitor, Friday, May 21, 1999

- Continuous quality improvement training was provided for 19 UPMA private midwives, including two midwives from the UPMA clinic. Training included developing CQI teams, identifying quality problems, utilizing tools for obtaining data and monitoring and evaluating interventions, and developing quality action plans. Follow-up visits were conducted three months after training. Findings showed that 100 percent of the trained midwives had developed CQI teams at their clinics, were addressing quality problems and were actively seeking input and feedback from clients.

Objective 5: To improve UPMA's management capacity, including its capability to monitor and control costs and to effectively and efficiently manage an endowment income.

- Renovations were carried out at UPMA headquarters to increase security (e.g. compound wall built, security bars installed, ceiling erected), improve access (e.g. land graded, parking area developed, steps made), enhance more efficient utilization of space (e.g. porch enclosed to expand office space), and improve standards of work environment (e.g. pit latrine renovated, sink installed).
- Office equipment was provided for UPMA headquarters (e.g. two computers, two printers, a photocopier, a fax machine, desks and filing cabinets) and for the UPMA clinic (two computers, a printer, desks and filing cabinets).

Kansanga gets a nursing home
By Josephine Maseruka

The Director of the USAID Mission in Uganda Ms. Dawn Liberi has urged Ugandans to practice birth spacing to reduce the high population growth and reduce health problems.

"Uganda has one of the highest population growth rates in sub-Saharan Africa and the most immediate challenge for reproductive health in many countries is the sheer growth in population.

She was launching the Family Nursing Home Kansanga, the first privately owned clinic and training center for the Uganda Private Midwives Association (UPMA) Wednesday. She represented the US Ambassador, Nancy Powell.

The sh200m storeyed building has been put up by USAID assistance to sustain UPMA which was founded in 1948. USAID has been funding the association through the SEATS programme.

It has maternity, male, female and children wards, with a theatre and clinic. Liberi regretted that between 20 to 40 percent of births in developing countries are unwanted.

Source: The New Vision, Friday, May 21, 1999

- UPMA administrative staff were provided with computer training in word processing and spreadsheet creation (Word Perfect, MS Word, LOTUS and Paradox).

- A local accounting firm was contracted to conduct an initial assessment of UPMA's financial management procedures and capabilities. Based on these findings and the projected expansion of UPMA's activities, including owning and operating a clinic and undertaking multiple donor-funded projects, the accounting firm assisted UPMA over a period of 15 months to develop a comprehensive system of guidelines, documentation and procedures for proper accountability of income, disbursements and reporting. Areas of technical assistance included providing on-the-job training for the bookkeeper and administrator, establishing financial management systems, developing manuals (guidelines) for systems and operational procedures, developing procedures and mechanisms for processing transactions, preparing a strategic plan for implementing the financial management system, and computerizing the system. The system was designed to meet both internal (UPMA) and external (e.g. donor-funded projects, auditors) needs and requirements. As a result, UPMA financial management capability has progressed from a basic, manual bookkeeping system that lacked procedural guidelines and controls to a sound financial management system that is computerized, controlled by clear procedural guidelines and meets both internal and external requirements for accountability.

- On-the-job training in financial management was provided for the UPMA Administrator and bookkeeper by the financial advisor to the Board of Directors. The areas of instruction included management, analysis and reconciliation of petty cash; management and recording of expenditures; budget development and monitoring; and bank reconciliation.

- MAPS and CMS assisted UPMA in the recruiting, hiring, and orienting of an Executive Director to be responsible for the oversight of UPMA as the Association rapidly expands into a broader range of membership services, a more complex financial management system, owning and operating a for-profit clinic, securing additional donor-funded projects, and operating an emerging training center. The daily coordinating and oversight of UPMA activities has exceeded the capability of the volunteer Executive Committee. The Executive Director also brings extensive marketing, personnel and financial management skills to UPMA which are essential in the next phase of enhancing the sustainability of UPMA: efficient operations, marketing of services, networking, improving quality, enhancing customer relations (members and clients), and self-sufficiency through a diversified, profitable funding base.

- A personnel policy manual was developed to standardize and guide UPMA policies for both headquarters and clinic staff.

- A workshop was conducted for 15 UPMA leaders and selected administrative staff to assess the organization's current status (February 1999), identify and prioritize needs, and plan strategically for the future. Three key areas were identified as the focus for UPMA strategy: membership (e.g. recruitment, services, geographical coverage, subscription fees), management (e.g. organizational structure, Constitution, management systems, branches) and sustainability of the Association's programs. With technical assistance from the Center for African Family Studies (CAFS) and CMS, a strategic plan and five-year cash-flow projection were developed.

- The UPMA Chairperson and the MAPS Resident Advisor attended the SEATS regional workshop on quality/monitoring and evaluation held in Harare, Zimbabwe. The workshop focused on improving linkages between the CQI process and monitoring and evaluation, and strengthening the evaluation of quality of care in SEATS II subprojects. In addition to providing a refresher exposure to CQI techniques, it also emphasized the need for each quality action plan to have a monitoring and evaluation component with measurable objectives, appropriate indicators linked to each objective and appropriate data sources for the measurement of each indicator.

- MAPS developed the software for a computerized membership database system, which was field tested in Zimbabwe (Zimbabwe Nurses Association) and Zambia (Zambia Nurses Association). This system was adapted to meet the specific needs of UPMA. Previously, membership information was manually recorded, an inefficient system making it difficult for UPMA to access or update needed information. After installing the computerized system, UPMA administrative staff and executive leaders were trained in its use, forms were developed to collect data from the membership, and a user manual was developed. Once all membership data is entered into the computerized membership data base, UPMA will have the capability to track, locate and reach members (mailing labels), query information through selected sorting, monitor continuing education and other quality interventions, track payment of subscription fees and generate reports for making management decisions.

- An audit was conducted for the purpose of project accountability and to assess UPMA's capability for managing project funds. The results of the audit showed that UPMA/MAPS management complied in all respects, including grant agreement terms and applicable laws and regulations.

Objective 6: To develop linkages between UPMA and other midwifery associations through the MAPS Africa Regional activities and the American College of Nurse-Midwives, in order to gain exposure to innovative approaches to improving and sustaining services and to market UPMA's resources to regional associations and private midwives.

- A regional study tour to Uganda was conducted for 12 private midwives from the Independent Clinics Organization (ICO) in Zimbabwe and the Association Nationale des Sage Femmes du Senegal (ANSFS). The goal of the study tour was to facilitate collaborative efforts and sharing of experiences between the three professional associations. In addition, the activity sought to enhance the exchange of ideas and experiences through group discussions and provision of on-site observations of clinical practice; to improve the quality of and access to FP/RHC services through a sharing of lessons learned; and to develop a collaborative relationship for ongoing networking between the three associations. Activities included visiting the UPMA headquarters and model clinic site; a workshop to discuss private practice issues; and pairing of the guest midwives with Ugandan midwife counterparts who lived and worked together, sharing common problems and learning from each other's strengths and experiences. Each midwife who participated in the study tour identified three actions that she planned to implement at her clinic based on what she learned during the study tour, that would improve the quality of and/or access to FP/RH services in her clinic. A follow-up was conducted six months later and showed that 91 percent of the study tour midwives had implemented more than half of their intended quality

actions. Examples of actions undertaken include: developing a clinic reference library for staff, following up on referred clients, installing suggestion boxes, constructing incinerators for disposal of contaminated supplies, improving supervision of clinic staff, and devoting a separate room for counseling of clients. The tour provided a unique opportunity for the midwives to exchange ideas and experiences and develop south-to-south relationships for ongoing networking between the three associations, in order to improve reproductive health care service provision by private midwives.

- Two Ugandan trainers conducted business management and community mobilization training for 19 private ICO midwives in Harare, Zimbabwe. Pre- and post-tests showed improved knowledge for 100 percent of the trainees.

- A study tour to Uganda was conducted for two leaders of the Zambia Nurses Association (ZNA). ZNA is developing a proposal to seek funding for the development of an association-owned clinic and lobbying for the passage of an act that would sanction private practice by nurses and midwives. In Uganda, the ZNA leaders were provided with the opportunity to visit the UPMA model clinic, visit UPMA members' private clinics, and meet with the UNMC to learn about requirements for midwives opening and operating an independent clinic.

- Ten UPMA midwives attended the international MAPS Dissemination Conference held in Harare, Zimbabwe, where they gave presentations on "SEATS and UPMA: Three Generations," developing an association-owned and operated model clinic and training site, and business management and community mobilization training.

- Ten UPMA midwives participated in a MAPS regional workshop held in Harare, Zimbabwe, for midwives from Zimbabwe, Zambia, Tanzania, Eritrea, Cambodia, Uganda and the United States. The focus of the workshop was to explore ways in which to expand the role of the professional association in assisting midwives to increase access to and quality of RHC services. UPMA midwives gave presentations on membership services and lessons learned in developing an association-owned model clinic and participated on a panel that addressed developing linkages between the professional association, private midwives and the community.

- Two UPMA leaders were sponsored to visit SEATS' youth programs in Lusaka, Zambia and in Gweru, Zimbabwe in order to facilitate the integration of youth-friendly services at the UPMA and private midwives' clinics in Uganda.

- MAPS assisted UPMA in developing e-mail capability and linking the Association with other nursing and midwifery associations on the Internet.

Although MAPS II met all of its objectives, there were constraints encountered that resulted in the revision of targets or limited the extent to which an objective could be met. These constraints included the following:

- At the outset of the subproject, USAID/Uganda agreed that non-DISH district members of UPMA could receive DISH training. However, the MAPS Project would have had to fund their training. Consequently, no non-DISH midwives could be trained.

- Frequent power outages in the UPMA headquarters area delayed the initial computerization of the financial management system and computer training for headquarters staff.

- Prior to the renovations, armed thieves broke into UPMA headquarters, damaging the building and destroying important documents. The headquarters was temporarily relocated to the training room at the new clinic, creating crowded working conditions and delaying the use of the training center until the end of the project.

- USAID/Uganda's primary expectation for the subproject was the development of the UPMA clinic. The clinic consumed considerably more time and funds than were initially projected due to unavoidable delays with contractors, obtaining permits, legal requirements, procuring equipment and supplies, etc. Costs for supplies increased while the local currency was devalued. Consequently, the clinic opening was delayed by six months and was the primary focus for interventions during the first 15 months of the subproject while levels of intervention for other activities were reduced. Most notable was in the assistance to aspiring private midwives, with the target decreased to 50 midwives identified, instead of 100 identified and 50 having opened practices. Remaining time was insufficient to conduct supervised training of the four continuing education modules or make follow-up visits to the last 30 midwives to be trained in business management and community mobilization.

- Marketing strategies promoting the UPMA clinic included public service messages (newspaper articles and radio messages) and customary practices for increasing access (pamphlets and signboards). Despite efforts to abide by regulations on the advertising of medical services, the Medical and Dental Council banned continuation of these ads, contributing to a lower number of clients than anticipated.

- During the subproject design phase, USAID/Uganda recommended that UPMA seek an endowment and that SEATS assist UPMA in preparing a proposal. During PY1, it was determined that endowment funding would not be available during the subproject, although USAID/Uganda did not discount the possibility in the future.

- Service statistics for this subproject were to be generated by the UPMA clinic and aspiring private midwives opening new clinics. Because these activities were delayed or downsized, service statistics were not reported until Q3/99.

Appendix 4 includes a complete list of references and documents which provide details on all aspects of the design, implementation and evaluation of this subproject.

V. ACCOMPLISHMENTS

The previous section (IV. Project Implementation) outlined the interventions SEATS has undertaken in Uganda and Appendix 4 offers an extensive list of documents providing additional details on these activities. It is important, however, to consider the overall contributions SEATS II has made to Uganda's national FP and RHC programs and the value SEATS has added toward the achievement of USAID/Uganda's Strategic Objective and Intermediate Results.

A. Improved Access to FP/RHC Services

SEATS II has contributed specifically toward improving access to the services of midwives in the following ways:

- A Community Mobilization curriculum was developed, and 241 private midwives were trained.
- Follow-up site visits to 143 midwives trained under MAPS I showed a 10-26 percent increase in clients per month; visits to 58 trainees from MAPS II showed that, within six weeks of training, 59 percent had implemented their community action plans.
- MAPS' interventions resulted in 245 new and/or improved SDPs.
- A follow-up questionnaire of 79 of the 83 aspiring midwives indicated that 48 had opened new practices. Twenty-five midwives anticipated opening a practice by the close of 1999, the majority indicating that they had purchased equipment, found a location and/or applied for a practice permit. In the same questionnaire, the midwives were asked how UPMA could further assist them in either opening a practice or to better establish an existing practice. The most frequently stated suggestion was provision of continuing education (especially in business management and FP/RHC), followed by assistance obtaining equipment at affordable costs and providing support/monitoring site visits.

Chart 1 shows the number of new acceptors/new users as well as returning clients in the SEATS-assisted SDPs during MAPS I. The increase in number of clients served and commodities dispensed would have been higher with complete reporting. At the beginning of 1997, the SOMARC Project discontinued support to the market day midwives program, and MAPS had relied on their reporting mechanism to collect the data for the market midwives SEATS had trained. The discontinuation of support also caused some market stalls to close. In addition, rumors spread that the MAPS I subproject had closed due to funding cutbacks, and the number of midwives submitting service data dropped significantly.

The MAPS I subproject exceeded its CYP projection of 10,000, generating a total of 22,829 CYP, which suggests a steady increase in contraceptive usage and continuation. Chart 2 shows CYP generated by method per quarter.

Chart 1. New and Returning Clients

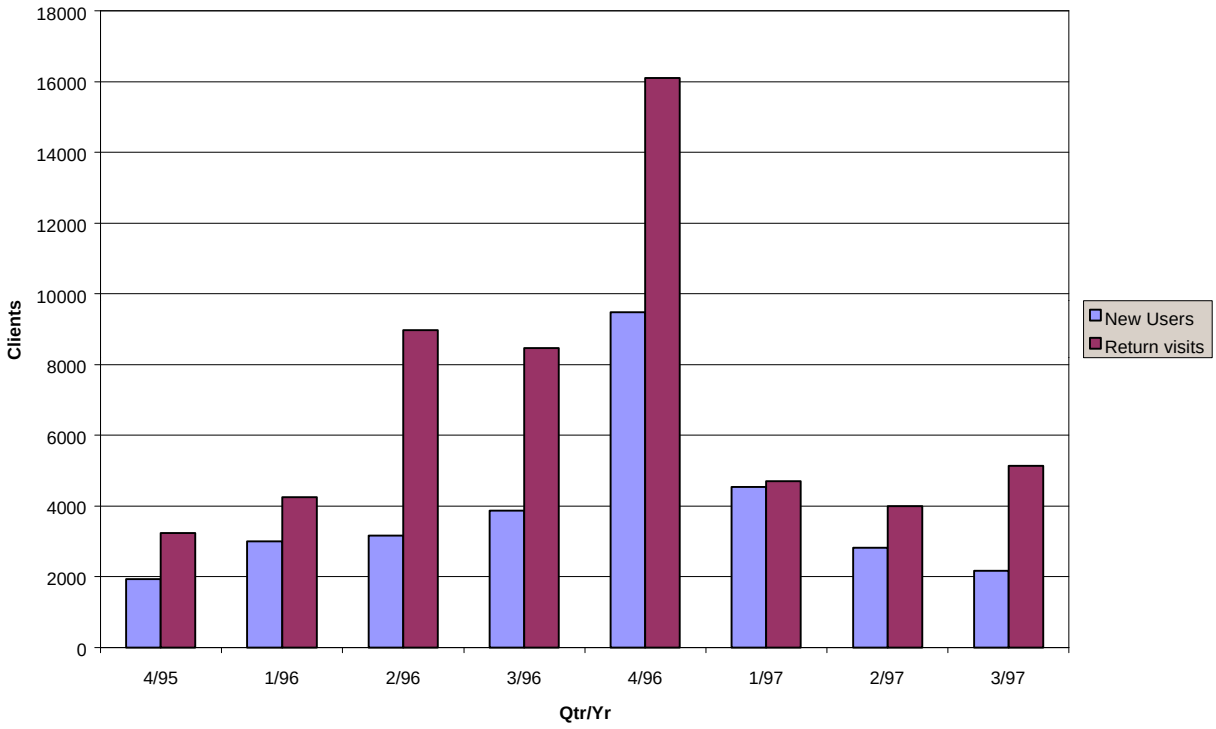
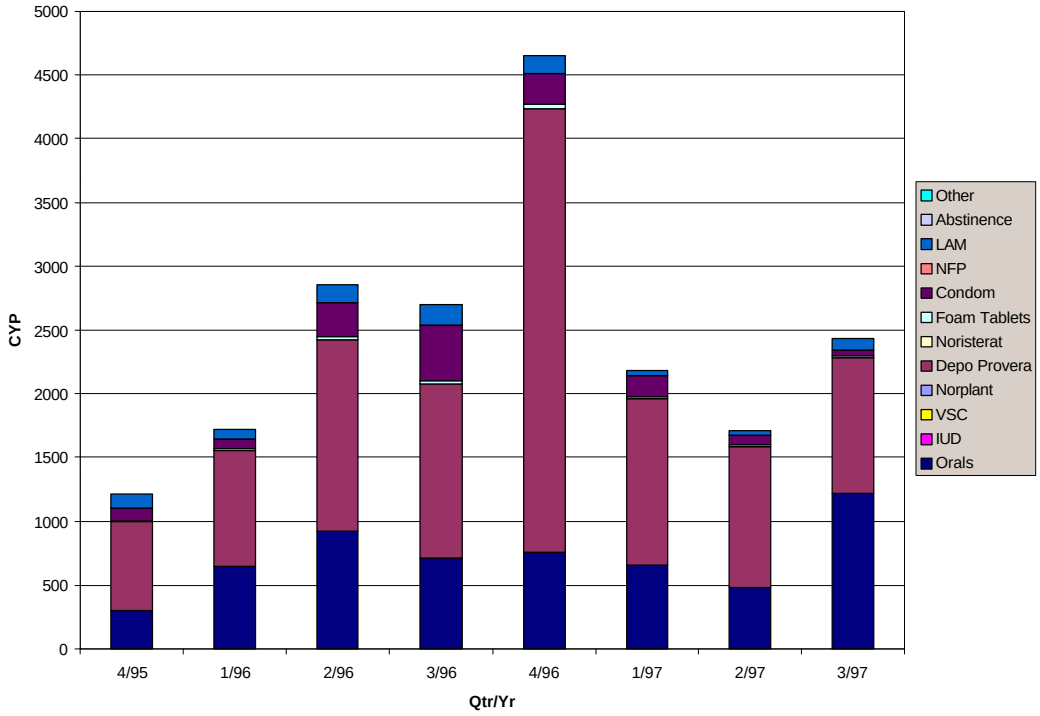


Chart 2. CYP by Method



B. Improved Quality

In general, private midwives are anxious to provide high-quality services because the viability of their practices relies on word of mouth from satisfied clients. In addition, midwives' personal and professional reputations within the community are linked with their clinics and their services. Improving quality was addressed in a variety of ways during the two MAPS subprojects.

1. Method Mix

Method mix during MAPS I was improved by including Norplant™ as a FP option, and 81 clients were referred. There was also an increase in the number of client-acceptors of long-term (Depo-Provera) and permanent methods. The decline in the number of condoms distributed was directly related to public response to a vigorous mass media campaign by religious leaders speaking out against condom use.

2. Training and Continuing Education

- MAPS facilitated the inclusion of 88 private midwives in the DISH FP/RHC training (76 were UPMA members) which focused on aspects of quality. MAPS conducted a study of the training evaluation results for the private midwives in order to determine the level of improved knowledge and skills. The findings showed that 93 percent of the midwives trained during MAPS I (N=37) showed improved knowledge post training, with the highest levels of improvement in counseling clients, prevention of infection and group client education. Improvement in skills was greatest in performing pelvic exams for STIs, counseling high-risk clients, performing physical exams and obtaining histories.

- A similar training assessment was conducted during MAPS II (N=51), and there was, again, an overall improvement in skills. Follow-up visits showed excellent retention of skills, with most areas showing an improvement in assessment scores. The average scores by skill are presented in Table 2. Looking at all trainees together, skills assessment scores were higher not only immediately following the training (post-test), but were found to be even higher during the follow-up assessments. This suggests a strong retention of skills which at least strengthens the potential for improved quality as a result of the DISH training.

Table 2. DISH Training Average Scores by Skill for Midwives during MAPS II (N=51)

Area	Pre-Test	Post-Test	Follow-Up
Conducting group client education	65.67	76.53	77.20
Counseling high-risk clients	55.69	72.70	75.12
Obtaining antenatal history	56.50	80.45	82.17
Performing physical exam	46.37	75.09	78.50
Performing pelvic exam	62.12	72.84	76.08
Observing infection precautions	78.75	85.14	87.60
Counseling for informed choice	86.90	89.67	91.46
Initiating OCs	86.25	85.20	84.56
Admitting labor client	90.11	95.59	94.36
Conducting delivery	86.16	93.27	93.33
Applying syndromic STI management	89.79	91.66	89.94
Performing newborn exam	90.68	91.42	92.00
Average	**74.59**	**84.13**	**85.19**

- FP/RHC continuing education updates were included at monthly national meetings by the Project Coordinator. Although pre- and post-tests were not conducted, the membership survey showed that the most frequently stated reason for attending UPMA meetings was to receive FP/RHC updates.

- MAPS assisted UPMA to develop four continuing education modules (Continuous Quality Improvement, Counseling FP Clients, FP Service Provision and STI Management), train four trainers and develop a training room at the UPMA clinic. The shortened time frame for implementation of subproject activities precluded conducting supervised trainings, but UPMA has acquired the capacity to offer continuing education in these areas. The modules were revised following the initial TOT to include concepts of quality of care in each module, and pre- and post-training evaluations were developed. A follow-up TOT was conducted to orient the trainers to these changes.

- CQI training was provided for 12 midwives, representing 15 SDPs. Two midwives from the UPMA clinic were included in the CQI training and all staff from the UPMA clinic participated in a quality of care workshop. Follow-up findings were presented in Section IV. Project Implementation. Trained midwives formed CQI teams and were actively addressing quality problems at their clinics and seeking feedback from clients and the community.

3. Standard Setting

- Standards for private midwifery care were developed, and a linkage between UPMA and the UNMC was formed to move forward the process of obtaining approval from the MOH and the implementation of the standards. The UNMC, UPMA and MOH are currently in the process of updating the Nurses and Midwives Handbook (Protocols for FP/RHC), which was developed in 1993. MAPS conducted a baseline study to determine the current level of compliance to 6 of the standards by a sample of 43 midwives in 4 districts. The data are presented in Table 3.

Table 3. Performance on Selected Standards (N=43)

Standard	Indicators	Total Passing
Licensed to Practice Private midwifery practice is provided by a qualified, registered/enrolled midwife who is licensed to practice and a member of UPMA.	1. Has a certificate of qualification in midwifery. 2. Is a member of UPMA. 3. Has midwife handbook.	97.7%
Client Safety The midwife provides services in an environment and on premises that are safe for the client, community and health care providers according to the requirements set by UNMC and the Midwives Handbook and Guide to Practice.	1. Has chlorine; sterilizer/boiler; gloves; container for disposal of sharps; bucket for soaking contaminated equipment; container for contaminated supplies; placenta pit or incinerator; hand washing facility. 2. Knows correct time for sterilizing. 3. Knows correct time for disinfecting.	72.1%
Clients' Rights The midwife has the knowledge, skills and attitude to ensure clients' rights and the provision of satisfying care.	1. Has provision for visual privacy. 2. Has provision for auditory privacy. 3. Client records kept in a secure place. 4. Has suggestion box.	81.4%
Interpersonal Relationships The midwife develops good interpersonal relationships with clients including recognition of the socio-cultural, economic and political background, provision of comprehensive information on RHC services and support for decision-making for each client.	1. Has two or more IEC materials displayed/ available. 2. Has teaching/visual aids. 3. Has IEC materials addressing the needs of youth. 4. Has a variety of information on FP methods for clients.	81.4%
Referral Systems The midwife works in collaboration with other health workers, referral centers, community and local authorities to promote an effective referral system.	1. Keeps referral record book. 2. Has established referral points for HIV clients. 3. Has established referral points for OB problems/ emergencies. 4. Has established referral points for VSC clients. 5. Evidence of recorded follow-up on referred clients. 6. Has taken actions to make community aware of services.	32.6%
Recordkeeping The midwife documents information clearly, accurately and completely to facilitate client follow-up, evaluate services and conduct research.	1. Takes and records BP for OC clients. 2. Records type of FP method. 3. Records timing/ follow-up for next visit. 4. Records clinical findings for clients who were examined.	70.0%

Overall, for five out of the six standards studied, at least 70 percent of midwives achieved a passing score. The most difficult standard was the one on referral systems, where only 33 percent of midwives passed, mainly because most midwives failed to keep a separate referral book or to follow up on clients referred. Nineteen percent of midwives achieved a passing score on all six standards, while 93 percent passed at least three. These results are fairly encouraging given that the concept of standards for midwives is relatively new. Even so, there is substantial room for improvement, and these results can serve as a useful baseline for UPMA to measure progress against in the future.

4. Community and Client Satisfaction

- Community leaders were asked questions to address not only quality in fact, but also quality in perception. The results showed that 100 percent of the leaders were aware of the services offered and would recommend them. The most frequent reasons given for recommending were that the midwives treat clients with respect and "really care," the services are affordable, the midwives are experienced and trusted, they offer quality services, and the services are convenient.

- A small number of clients (N=32) were questioned using exit interviews to assess their satisfaction with services. The results showed that 100 percent would recommend the services. The most frequently given reasons were that the services were convenient and affordable, the available services met their needs, that respected others also came to the clinic, and that they were treated very well. All clients felt that they had received adequate privacy and that their personal information would be kept confidential.

- Results of the baseline study will guide UPMA and UNMC in determining the interventions required to improve quality of services offered by private midwives. Immediate follow-up was conducted to those midwives identified in the study whose practices were considered to be potentially unsafe (e.g. disinfecting and sterilization procedures were insufficient).

5. Evaluation of Program Interventions

- As part of a larger, mostly qualitative study to evaluate the impact of MAPS subprojects in Uganda, Zambia and Zimbabwe, a sample of Ugandan private midwives (N=12) was interviewed in May 1999. Eleven sites were visited and exit interviews were held with 79 clients. Results of that study showed that all of the midwives felt they had benefited from the SEATS/UPMA subprojects by improving the quality and range of their services, interacting with the community and having more educational opportunities offered through UPMA. Similar to the above findings, one hundred percent of the clients expressed satisfaction with the services of the midwives and would recommend the clinics to others.

- Nine midwives reported an increase in their number of clients. The most frequently cited reasons for this increase were greater community awareness and that the midwife had acquired new skills. Community outreach activities included meeting with youth groups, health talks at local functions and schools, and home visits. The desire to provide quality care was stated as the greatest reason for entering private practice.

- To assess factors that might affect quality of and access to services, specific areas were addressed in the study. Midwives were asked about how they identify areas needing improvement; how they make their services responsive to clients' needs; special groups they may target; existence of barriers; and referral practices, among others. Client interviews focused on reasons for visits; their comfort level; privacy issues; and overall satisfaction with midwives' services. (Appendix 3. Client Interview Data)

C. Improved Institutional Capacity and Sustainability

By 1995, UPMA and most private midwives had recovered from the devastation of civil war. Several midwives had been trained as family planning service providers under SEATS I, the SOMARC Project had incorporated private midwives and UPMA into the FP social marketing program; the DISH Project offered the potential for additional FP/RHC training, and the GOU recognized the need for development of the private sector. At the same time, however, UPMA had very limited managerial capability and relied almost exclusively on membership dues and limited donor funding through the SOMARC Project to maintain its headquarters and programs. Its sustainability was not assured.

Sustainability of programs is at the core of all SEATS subprojects, and MAPS promotes sustainability by working through professional midwifery associations. Building the institutional capacity of UPMA was an objective of MAPS I and MAPS II in order to strengthen both the Association and its members. Achievements included:

- Through needs assessments, strategic planning, sustainability and quality of care training, and membership surveys, UPMA has been assisted to assess their current situation and plan constructively for the future based on clearly defined goals and objectives.

- The organizational structure and governance of UPMA has been streamlined and made more efficient and effective through the development of a Board of Directors, working committees, standardized policies and guidelines for association staff, and incorporation of an Executive Director.

- UPMA leaders and administrative staff have gained skills in computer programs, financial management and leadership. A computerized financial management system was installed, a user manual developed and training provided. UPMA now has the capability of managing Association, clinic and project funds and providing a level of accountability that meets audit requirements.

- The Association headquarters has telephone, fax, email, photocopying and computer capability; the building has been renovated for effective utilization of space; and the property has been made secure.

- A membership drive has been instituted, resulting in a growth in membership.

- Aspiring private midwives have been identified and UPMA is developing ways to assist these midwives, helping to ensure the future viability of the Association and meet growing FP/RHC demand in the private sector.

- In addition to its SOMARC trainers, UPMA now has seven trainers in business management and community mobilization skills, four FP/RHC trainers, as well as a training facility and curricula. This training capability will continue to attract new members, meet continuing education needs of current members and provide an income-generating source for the Association.
- Membership data has been computerized, facilitating the tracking, monitoring, and communicating with members.
- Through MAPS-sponsored activities, UPMA has developed private practice standards in collaboration with UNMC, initiated the CQI process at several clinics and developed regional and international linkages with other professional associations for sharing of resources and experiences.
- Extensive collaboration with other CAs and projects (e.g. SOMARC, CMS and DISH) have led to the efficient use of resources, the reinforcement of consistent and successful technical approaches, broad-based support for capacity building and improved potential for sustainability.

Groundwork for greater financial self-sufficiency of UPMA has been laid through financial management training and the development of an Association-owned and operated clinic. The clinic will provide a model for private midwifery practice, a practicum training site to expand the continuing education offerings and an income generating source to help sustain Association overhead and programs. Over the next two to three years, it is anticipated that the income from the clinic will significantly decrease UPMA's dependence on donor funding for essential programs and recurrent Association costs. Initially, the clinic generated about $1,500 per month and was generating close to $2,000 per month by the end of the subproject. It is anticipated that the clinic income will continue to grow, reaching $5,000 per month within a year of its opening.

UPMA leaders participated in a SEATS regional leveraging workshop, where they received an introduction to fund raising and proposal writing. MAPS also assisted UPMA in leveraging funds to expand its programs and capabilities through direct TA in identifying potential donors and developing proposals. These leveraging activities are presented in Table 4.

Table 4. Leveraging Activities

Donor	Activities	Duration	Amount	Status
USAID/MFEP	Purchase and renovate building for UPMA clinic.	1998	$165,000	Completed
USAID/MFEP	Pay legal, registration, inspection fees for clinic; purchase drugs.	1999	$10,750	On-going
Bancker-Williams	Expand training facility.	1999	$35,000	Rejected; invited to re-apply
UNFPA	Train 20 midwives in LSS; train seven trainers; train 80 traditional birth attendants.	6/98 to 5/99	$60,000	Completed
UNFPA	Train 20 midwives in LSS.	1/99 to 1/01	$110,405	Approved
WHO	Produce radio messages in Buganda (local language) to reduce maternal/ perinatal mortality and morbidity.	1/98 to 12/98	$1,631	Completed
WHO	Produce radio messages (in additional local language) to reduce maternal/ perinatal mortality and morbidity.	To be determined	To be determined	Pending
Family Care International	Sensitize 90 midwives on RHC needs of adolescents and make services more youth-friendly; promote community mobilization on adolescents' RHC needs.	11/98 to 4/99	$13,590	Approved
MOH/World Bank	Train midwives in STI management and counseling.	1998	$3,308	Completed
CMS	Develop and implement marketing strategies for UPMA clinic	1999	$20,000	On-going
CMS	Fund Executive Director of UPMA	Beginning 11/99	$24,000/ year	On-going

At the end of 1999, the institutional capability of UPMA is greatly improved, and it is well positioned to enter the next century as a leader of FP/RHC services and an advocate for private midwives.

VI. KEY LESSONS LEARNED

SEATS' partnership with UPMA and private midwives in Uganda has been rich in lessons learned. Each subproject has built on prior experiences and lessons. Presented below are some of the more noteworthy lessons learned. These can help guide future programs in Uganda as well as in other countries seeking to develop the under-utilized resource of private midwives in the provision of FP/RHC services.

- Private midwives are highly motivated to provide quality services as their reputation in the community and their livelihood depend on it.
- Private midwives provide affordable alternatives for clients who can afford to pay a reasonable fee for quality services, thus relieving some of the burden on public facilities. A study of 79 clients showed that 95 percent chose the services of the private midwife over other available options (e.g. public clinic, private doctors), citing quality of care and affordability as reasons.
- Private practice offers an option to midwives who are leaving public service and who otherwise would be lost to the national health care delivery system.
- The demand for FP/RHC services is growing in Uganda, and most women need to work in order to support large families, especially in the wake of losing working age family members to AIDS.
- Vibrant professional associations such as UPMA are able to successfully leverage additional resources from multiple donors, but require capacity building to ensure that they can manage multiple programs effectively.
- Midwives with community mobilization training actively seek interaction with and feedback from the community and clients. This was shown to result in a significant increase in the number of clients accessing their services.
- Basic business management skills are critical to the viability of private midwives, yet most private midwives lacked this training prior to SEATS. Budgeting is one of the most difficult concepts to learn and utilize. Cultural practices have not provided women with the experience of having or handling money and property of their own. This change in thinking and planning is a gradual process that requires special emphasis in the training curriculum as well as on-the-job follow-up and supervised practice.
- Working with midwives involves consideration of gender barriers. Most midwives wishing to open their own clinics in Uganda are denied access to start up capital, as they do not own property for collateral and microfinance programs do not extend the level of credit needed or terms of repayment that are realistic for developing a clinic. In some instances, midwives become the targets of domestic violence once they begin to earn money of their own.

- One of the reasons private midwives are such a valuable resource in reaching clients and communities is that they are "near the people." This proximity to the communities also means that they are dispersed widely throughout the country and it is a challenge to work with them when implementing and monitoring a program that targets their services.

- To sustain project interventions and successes, UPMA must be assisted with capacity building (to strengthen the link between the midwives and the Association and the Association's link with an external network of resources) and with developing a strong managerial capability and a diversified financial base.

- Collaboration and networking with sister countries contributes to the improvement of quality of care by sharing lessons learned gained from the experience of others.

VII. RECOMMENDATIONS

The lessons cited in this report suggest directions and approaches that SEATS would recommend to the GOU, USAID/Uganda and other CAs working in Uganda to consider for future FP/RHC programs. The climate in Uganda for continued work with private midwives is excellent. The GOU is supportive of private sector initiatives; USAID/Uganda intends to continue support for interventions with UPMA; the three-year DISH II Project (1999-2002) will continue FP/RHC training initiated under DISH I; and the CMS Project is committed to ongoing assistance to UPMA. In addition, UPMA has initiated programs in collaboration with other donors such as the United Nations Population Fund (UNFPA). SEATS presents the following recommendations regarding current and future activities:

- USAID/Uganda should continue its practice of promoting and facilitating collaboration and coordination among various CAs, donors, programs and in-country institutions. Such efforts help to increase efficiency, maximize resources and enhance the potential for sustainability.

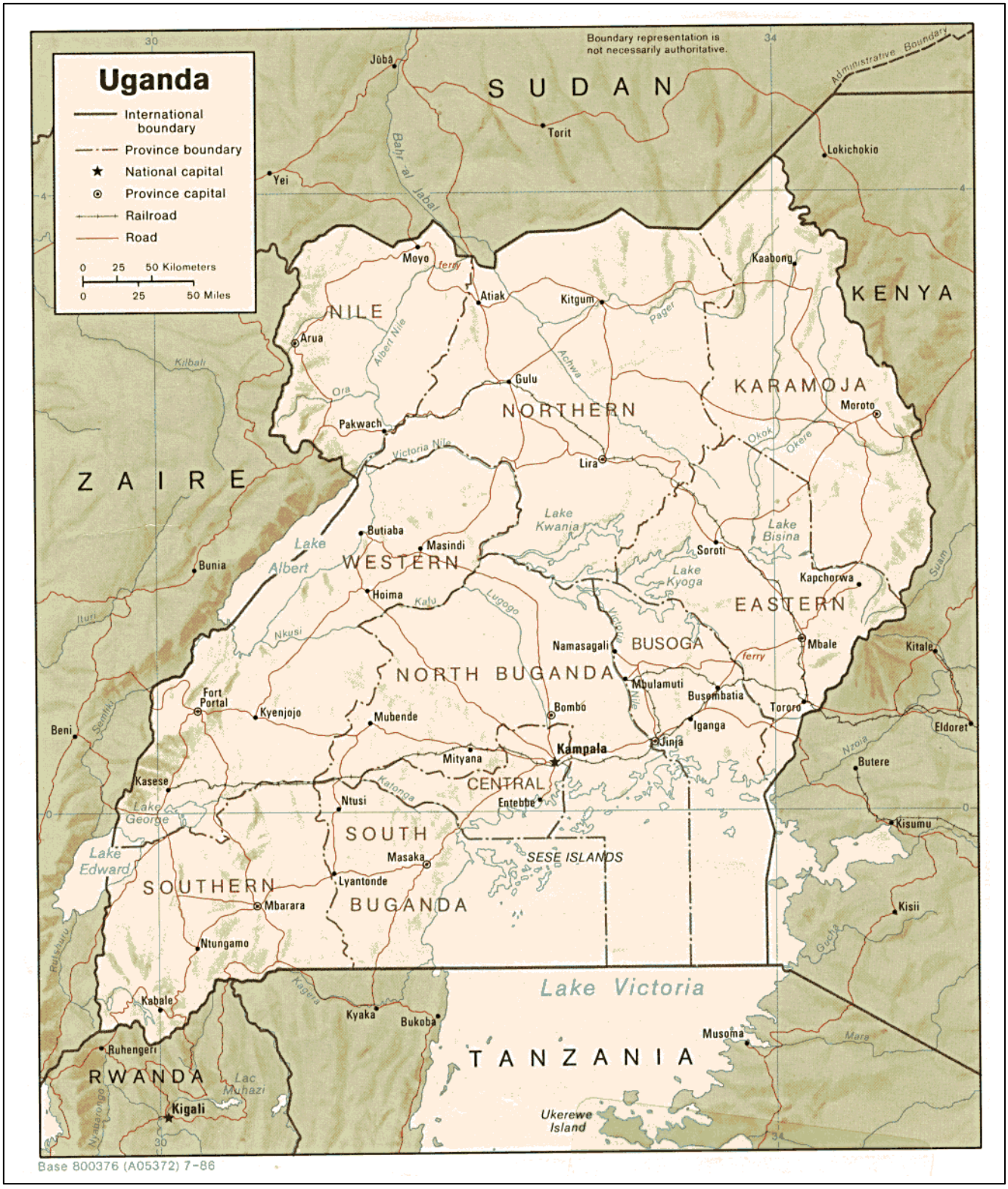
- Although UPMA has grown tremendously in its organizational and financial management capability, many of the skills are complex and new. In addition, the executive leaders are elected volunteers and are subject to turnover and multiple demands on their time. UPMA will continue to need guidance and on-the-job reinforcement of management skills in order to become confident and proficient. A mechanism of staggered turnover of Executive Committee members and careful orientation of newly elected leaders and newly hired administrative staff is essential for continuity and efficiency.

- USAID/Uganda should continue its support to UPMA. While the groundwork for diversifying and strengthening the financial base and eventual self-sufficiency of UPMA has been laid, the UPMA clinic has just recently opened and is not yet fully operational. Continued support will allow UPMA to strengthen the clinic to the point that it is profitable and contributing significantly to the support of essential Association programs and recurrent costs.

- With the recent growth in UPMA's programs and staff, a management audit should be conducted to assess the effectiveness and efficiency of its operations and organizational structure. Technical assistance should be provided to assist UPMA to implement recommendations resulting from the audit.

- In order to monitor and evaluate the outcomes and effectiveness of major program interventions (e.g. training, implementation of standards, new management systems), follow-up and studies should be built into future program designs and budgets from the outset.
- The next phase of capacity building for UPMA should include a focus on the branches, which is the primary contact point between the Association and members. Strengthening leadership, management and training capability, and communications at this level would facilitate implementing and monitoring interventions with private midwives, increase new and active membership, and improve the effectiveness of the Association.
- To significantly increase the numbers of private midwives, a credit program needs to be developed that offers access to appropriate levels of funding with extended terms of repayment. This credit program should link UPMA with a local lending institution.
- A sustainable mechanism for supervision and monitoring compliance with standards needs to be developed. One approach could be assisting UPMA to revitalize the regional representative system. Some of the UPMA branches have already initiated steps to accomplish this by raising funds from members for transport. This would improve the collection of service statistics and improve communications between headquarters, branches and members – including providing accurate information regarding opportunities such as training.

Appendix – 1


Uganda
International boundary
Province boundary
National capital
Province capital
Railroad
Road
0 25 50 Kilometers
0 25 50 Miles
Boundary representation is not necessarily authoritative.
Administrative Boundary
SUDAN
KENYA
ZAIRE
TANZANIA
RWANDA
Jūbā
Torit
Lokichokio
Yei
Moyo
Atiak
Kitgum
Kaabong
NILE
Arua
Gulu
NORTHERN
KARAMOJA
Moroto
Pakwach
Lira
Butiaba
Masindi
WESTERN
Soroti
Lake Albert
Lake Kwania
Lake Bisina
Lake Kyoga
Bunia
Hoima
Kapchorwa
EASTERN
Namasagali
BUSOGA
Mbale
Kitale
NORTH BUGANDA
Mbulamuti
Busembatia
Tororo
Fort Portal
Kyenjojo
Mubende
Bombo
Iganga
Eldoret
Beni
Jinja
Kampala
Mityana
Butere
CENTRAL
Kasese
Ntusi
Entebbe
Lake George
Kisumu
SOUTH
Lake Edward
Masaka
SESE ISLANDS
SOUTHERN
Lyantonde
BUGANDA
Mbarara
Kisii
Ntungamo
Lake Victoria
Kabale
Kyaka
Bukoba
Musoma
Ruhengeri
Lac Muhazi
Kigali
Ukerewe Island
Base 800376 (A05372) 7-86

Appendix - 2

STANDARDS FOR PRIVATE MIDWIFERY PRACTICE

1. Private midwifery practice is provided by a qualified, registered/enrolled midwife who is licensed to practice and a member of UPMA.

2. A private midwife ensures competence in skills and updated knowledge and maintains them through continuing medical education.

3. The midwife provides services in an environment and on premises that are safe for the client, community and health care providers according to the requirements set by UNMC and the Midwives' Handbook and Guide to Practice.

4. The midwife has the knowledge, skills and attitude to ensure clients' rights and the provision of satisfying care.

5. The midwife assumes autonomy, responsibility and accountability for the effective management, use of resources and quality of care of all clients.

6. The midwife develops good interpersonal relationships with clients including recognition of the socio-cultural, economic and political background, provision of comprehensive information on reproductive health care services, and support for decision making for each client.

7. The midwife works in collaboration with other health care workers, referral centers, community and local authorities to promote an effective referral system.

8. The midwife documents health information clearly, accurately and completely to facilitate client follow-up, evaluate services and conduct research.

9. A private midwife's practice is monitored and evaluated by self and the authorities according to established standards and a quality assurance program.

10. The midwife practices within established policy guidelines and local and national laws.

Appendix – 3

CLIENT INTERVIEW DATA

Background Information on Private Midwives (N=12)

Descriptive Data	N (N=12)
Years in Private Practice	Range: 4-18; Average: 10.7
Continuing Education since 1991	SEATS FP training: 9 Regional Rep training: 3 DISH training: 8 Business Management training: 10 Com. Mobilization training: 10 Other FP/RHC training: 8 FP/RHC updates at UPMA meetings: 10
Utilizes UPMA reference library	10
Participated in Uganda, Zimbabwe, Senegal study tour	7

Background Information on Service Delivery Points

Background Information on SDPs	N (N=11)	%
Location		
High density urban	3	27.2%
Low density urban	2	18.1%
Rural	6	54.5%
Hours		
24 hours/day 7 days/wk	9	81.8%
8 a.m. - 10 p.m.	2	
Privacy provided for exams	10	90.9%
Water source		
Running water	9 (2 from neighbor)	90.9%
Stream or rainwater	2	18.1%
Signpost describing services	11	100%
Written guidelines for FP/RHC available	11	100%
Offer FP services/ counseling	11	100%
Offer STI services/ counseling	11	100%
FP services/ counseling added since 1991	9	90.9%
STI services/ counseling added since 1991	9	90.9%
Total clients per month	Range: 70-621 Average: 328	
FP clients per month	Range: 17-142	

	Average: 57	

Client Interview data (N=79)

Questions	Frequency of Responses
What was the reason for today's visit?	
Antenatal care	31
New family planning visit	6
Return family planning visit	16
Other	26
Have you visited this site for services before?	
Yes	64
No	15
Did you feel comfortable asking the midwife questions?	
Yes	75
No ("I was too shy")	1
No data	3
How do you feel about the information provided at your visit?	
Too	6
Too much	4
Just right	66
No data	3
Did you have a pelvic exam today?	
Yes	25
If yes, did you have enough privacy?	25
Yes	
Do you believe the information you shared about yourself will be kept confidential?	
Yes	72
No	1
No data	3
Where you satisfied with the length of time for your clinic visit?	
Yes	78
No	1

Questions	Frequency of Responses
How did you learn of this clinic?	
Word of mouth	60
Sign post	21
Met midwife at community function	5
Referred by family, friend, other clinic	8
Was there another clinic you could have gone to?	
Yes	75
If so, what type of clinic?	
Another private midwife	41
Private physician	53
Public clinic	18
Private hospital clinic	5
Traditional healer	2
Why did you choose to come to this clinic?	
Quality of services; loyalty to a clinic "who cares," services available; waiting time; cost of services (Note: most respondents cited all these reasons)	75
Only convenient clinic	4
Would you recommend this clinic to others?	
Yes	79

Appendix - 4

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